



Lifetime Consent Form

I request that payment of authorized Medicare/private insurance company benefits are made on my behalf to the Gashland Clinic and its physicians for any services furnished to me. I authorize any holder of medial information about me to release to the Health Care Financing Administration if I have Medicare. I further authorize my private insurance company access to any information needed to determine these benefits or the benefits payable for related services.

Patient's Name Printed

Patient's Signature

Date Signed

Name of Beneficiary if Different

Patient's Medicare Number

Beneficiary's Signature

Date Signed by Beneficiary